Pediatric & Adolescent Medicine

Patient Registration Form

Thank you for choosing Kaleidoscope Kids as your healthcare provider. ***Please fill out the form completely.***

Patient Information

Child's Name: ______________________________ Sex: M F
Last MI First

Address: ______________________ City: _________ State: _____ Zip: __________

SS#: ______________ DOB: ______________

How did you find out about Kaleidoscope Kids? ______________________________

Insurance & Guarantor Information

Responsible Person: ____________________ DOB: ________ SS#: ___________

Address: ______________________ City: _________ State: _______ Zip: _________

Telephone#: ____________ Work#: ____________ Mobile#: ____________

Email: ____

Primary Insurance Company: __________________ Telephone#: ______________

Insurance Company Address: ________________ City: _________ State: ______ Zip: ________

Subscribers ID#: ____________________ Group#: ______________________

Secondary Insurance Company: __________________ Telephone#: ______________

Insurance Company Address: ________________ City: _________ State: ______ Zip: ________

Subscribers ID#: ____________________ Group#: ______________________

(PLEASE PROVIDE INSURANCE CARD)

Parent / Guardian Information

Mother/Guardian's Name: __________________ DOB: _________ SS#: ___________

Address: ______________________ City: _________ State: _______ Zip: _________

Employment Status: ______________ Employer: ______________________

Telephone#: ____________ Work#: ____________ Mobile#: ____________

Email: ____

Father/Guardian's Name: __________________ DOB: _________ SS#: ___________

Address: ______________________ City: _________ State: _______ Zip: _________

Employment Status: ______________ Employer: ______________________

Telephone#: ____________ Work#: ____________ Mobile#: ____________

Email: ____

Emergency Contact

Name (someone who does not live with you): ______________________________

Address: ____________________ City: __________ State: _______ Zip: _________

Telephone#: ____________ Work#: ____________ Mobile#: ____________

Relationship to patient: __________________ Email: __________________

(OVER)

Assignment of Benefits/Consent to Treat

Consent to Treat/ Consent to Treat a Minor: I hereby authorize Kaleidoscope Kids/Meredith A. Byington, MD, P.A. the authority to treat and examine me/my dependent, and order any tests, diagnostic studies, treatment and other clinical services necessary for my own or my child's care and treatment.
Insurance Authorization/ Assignment of Benefits: I have given this office my correct and current insurance information. I agree it is solely my responsibility to notify the office of current insurance, address and telephone numbers. Should the information provided be incorrect, I agree to be responsible for any and all amounts billed to me. I hereby assign Kaleidoscope Kids/Meredith A. Byington, MD, P.A. all payment for surgical and medical services rendered to myself or my dependent. I understand that I am responsible for all co-payments, deductibles and amounts for services that my insurance plan does not cover, including out of plan services. I hereby authorize Kaleidoscope Kids/Meredith A. Byington, MD, P.A. to furnish my insurance carrier with information concerning my illness and treatment. I also authorize electronic transmission of my insurance claim to the carrier.

By signing below, I am confirming that I understand and agree with the above statements and that all information is true to the best of knowledge.

_______________________________________ _______________________________

Signature of Patient or Responsible party Date